

Certified Release of Information Specialist (CRIS) Certification Practice Test (Sample)

Study Guide



Everything you need from our exam experts!

This is a sample study guide. To access the full version with hundreds of questions,

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Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Don't worry about getting everything right, your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 - 45 minutes). Review a handful of questions, reflect on the explanations, and take breaks to retain information better.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning.

7. Use Other Tools

Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly — adapt the tips above to fit your pace and learning style. You've got this!

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Questions

- 1. A Pathology report is primarily concerned with which of the following?**
 - A. Heart rhythm analysis**
 - B. Analysis of tissue removed during surgery**
 - C. Patient's discharge instructions**
 - D. Initial patient assessment**
- 2. If a patient wishes to hand-carry copies of her records and those of her family members, what should you do regarding her husband's records?**
 - A. Reject all requests until her husband signs an authorization**
 - B. Process her and the child's request, reject husband's until authorized**
 - C. Process all requests due to her insurance coverage**
 - D. Process all requests as medical treatment requests are exempt from HIPAA**
- 3. What is a Subpoena Duces Tecum for healthcare records?**
 - A. A legal document directing the disclosure of health records without the patient's authorization for deposition or to a court**
 - B. A legal document signed by both attorneys in a lawsuit agreeing upon what information is requested from a healthcare provider**
 - C. A legal document appointing another person as the patient's representative for healthcare decisions**
 - D. None of the above**
- 4. Under what circumstance can PHI be disclosed without patient authorization?**
 - A. Only for treatment purposes**
 - B. Only in emergencies**
 - C. For public health and safety**
 - D. For routine business operations**
- 5. Why is the Designated Record Set significant?**
 - A. It includes the patient's entire medical history**
 - B. It is used to determine eligibility for insurance coverage**
 - C. It is the foundation for compliance with HIPAA regulations**
 - D. It informs patients about treatment costs**

- 6. What is the correct response if a mother requests her 17-year-old married son's medical records?**
- A. Deny the request because he is still a minor**
 - B. Ensure the son signs the authorization due to his status as an emancipated minor**
 - C. Have his wife sign the authorization instead**
 - D. Process the request since the mother is next-of-kin**
- 7. The authorization for release of medical records must include which of the following?**
- A. A list of all healthcare providers**
 - B. The purpose of the disclosure**
 - C. The patient's full social history**
 - D. A vague description of the records**
- 8. A valid authorization must include which of the following elements?**
- A. A patient's right to revoke statement**
 - B. A re-disclosure statement**
 - C. Signature and date by the patient**
 - D. All of the above**
- 9. What is the primary purpose of documentation within a patient's medical record?**
- A. To create a legal liability for the healthcare facility**
 - B. To ensure that communication between providers is effective**
 - C. To serve as a basis for advertising the facility**
 - D. To provide patients with unlimited access to records**
- 10. What is the difference between PHI and EPHI?**
- A. PHI refers to medical records only, while EPHI refers to transcribed notes**
 - B. PHI is any form of Protected Health Information, while EPHI refers specifically to Electronic Protected Health Information**
 - C. PHI is information shared with family, while EPHI is for healthcare professionals only**
 - D. There is no difference; both terms are interchangeable**

Answers

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1. B
2. B
3. A
4. C
5. C
6. B
7. B
8. D
9. B
10. B

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Explanations

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1. A Pathology report is primarily concerned with which of the following?

- A. Heart rhythm analysis**
- B. Analysis of tissue removed during surgery**
- C. Patient's discharge instructions**
- D. Initial patient assessment**

The correct answer focuses on the primary function of a pathology report, which is to provide a detailed analysis of the tissue samples obtained during surgical procedures. Pathologists examine these samples to determine the presence of disease, identify abnormalities, and provide diagnoses that guide treatment decisions. This process is crucial in a variety of medical contexts, especially in cancer diagnosis and other conditions that require tissue examination. The other options, while relevant to different aspects of healthcare, do not pertain specifically to the primary concern of a pathology report. Heart rhythm analysis involves cardiac function and is more related to cardiology. Patient's discharge instructions are important for post-treatment care and pertain to monitoring recovery and future health management. Initial patient assessment involves gathering comprehensive information about a patient's health status and history, which occurs before any pathological examination is conducted. Therefore, B is the most appropriate choice, as it directly relates to the core purpose of pathology reports in clinical practice.

2. If a patient wishes to hand-carry copies of her records and those of her family members, what should you do regarding her husband's records?

- A. Reject all requests until her husband signs an authorization**
- B. Process her and the child's request, reject husband's until authorized**
- C. Process all requests due to her insurance coverage**
- D. Process all requests as medical treatment requests are exempt from HIPAA**

The appropriate course of action is to process the requests for the patient and her child while rejecting the request for her husband's records until there is proper authorization. This is because, under HIPAA, patient information is considered confidential, and medical records cannot be disclosed to anyone, including family members, without explicit consent from the individual to whom the records belong. In this scenario, the patient is requesting access to her husband's records; however, since she does not have authorization from her husband to disclose his medical information, it is essential to maintain the confidentiality that HIPAA mandates. This approach upholds the ethical and legal standards of privacy, ensuring that the rights of the husband are respected while still accommodating the requests that are compliant with authorization requirements. By processing the patient's and child's requests, you are adhering to the rights they have to their own medical records, while also ensuring that the husband's privacy is protected until he can provide consent.

3. What is a Subpoena Duces Tecum for healthcare records?

- A. A legal document directing the disclosure of health records without the patient's authorization for deposition or to a court**
- B. A legal document signed by both attorneys in a lawsuit agreeing upon what information is requested from a healthcare provider**
- C. A legal document appointing another person as the patient's representative for healthcare decisions**
- D. None of the above**

A Subpoena Duces Tecum is indeed a legal document that directs a healthcare provider to produce documents, including health records, in a legal proceeding. This type of subpoena does not require the patient's authorization for the disclosure of their health information, as it is an order issued by a court or other authorized entity. The primary purpose is to ensure that relevant documents are made available for examination during legal proceedings, such as trials or depositions. Understanding this function is crucial for healthcare professionals, as they must comply with such legal requirements while also being aware of privacy laws and regulations like HIPAA, which generally protect patient information. The other options describe different legal documents or agreements which do not pertain directly to the mandate of producing records in a legal context, nor do they address the specific authority of a subpoena in the matter of healthcare records.

4. Under what circumstance can PHI be disclosed without patient authorization?

- A. Only for treatment purposes**
- B. Only in emergencies**
- C. For public health and safety**
- D. For routine business operations**

The ability to disclose Protected Health Information (PHI) without patient authorization is indeed permissible under certain circumstances, and one of the primary justifications is for public health and safety. When it comes to public health, healthcare entities may disclose PHI without consent to prevent or control diseases, injury, or disability, report vital events, conduct public health surveillance, or facilitate public health investigations. This is essential for protecting the larger community and implementing necessary health measures during public health emergencies, such as outbreaks or pandemics. In contrast, while treatment purposes, emergencies, and routine business operations may also have specific exceptions under HIPAA regulations, they often involve more nuanced requirements and limitations when it comes to disclosing PHI without patient consent. For instance, treatment disclosures are typically allowed but often require that the information is necessary for the provision of care. Similarly, while emergencies may allow for certain disclosures, they are contingent on immediate risks to the patient or others. Routine business operations also have strict guidelines and are usually limited to what is necessary for the operational functions, often still requiring some form of consent or notice to the patient. Thus, public health and safety presents a broader and more recognized justification for the disclosure of PHI without the need for prior authorization.

5. Why is the Designated Record Set significant?

- A. It includes the patient's entire medical history
- B. It is used to determine eligibility for insurance coverage
- C. It is the foundation for compliance with HIPAA regulations**
- D. It informs patients about treatment costs

The Designated Record Set is significant because it serves as the basis for compliance with HIPAA regulations. HIPAA, the Health Insurance Portability and Accountability Act, establishes specific requirements for the protection of patient health information. The Designated Record Set refers to the group of records maintained by a healthcare provider or health plan that is used to make decisions about individuals' health care and health plans. This set includes medical records, billing records, and any other documentation that is used to make clinical decisions about patients. By clearly defining and managing the Designated Record Set, healthcare organizations can ensure that they are safeguarding protected health information (PHI) and that patients have appropriate access to their medical records. Compliance with HIPAA not only protects patient privacy but also upholds the integrity of the healthcare system, ensuring that sensitive information is handled appropriately. In contrast, while options related to a patient's medical history, insurance coverage eligibility, and treatment cost information may involve parts of the records or their use, it is the specific legal and regulatory framework surrounding the Designated Record Set that makes it crucial for compliance with federal regulations governing health information.

6. What is the correct response if a mother requests her 17-year-old married son's medical records?

- A. Deny the request because he is still a minor
- B. Ensure the son signs the authorization due to his status as an emancipated minor**
- C. Have his wife sign the authorization instead
- D. Process the request since the mother is next-of-kin

The correct response is based on understanding the nuances of privacy laws and the status of minors, especially when it comes to medical records. When a 17-year-old is married, he is considered an emancipated minor. This means he has the legal rights and responsibilities of an adult, which includes making his own medical decisions and managing access to his medical records. Thus, the appropriate response is to ensure that the son provides a signed authorization for his mother to access his medical records. This respects both his status as an emancipated minor and his autonomy over his personal health information. The legal framework surrounding medical records emphasizes the importance of consent, particularly as it pertains to individuals capable of making their own health care decisions. In this situation, simply denying the request due to the son being "still a minor" misinterprets the implications of emancipation. Having the wife sign the authorization may not be necessary unless the policy explicitly requires it, but in this case, the son himself must provide permission since he can do so independently. While the mother may be considered next-of-kin, this classification loses significance in scenarios where the individual involved can legally handle their own medical information.

7. The authorization for release of medical records must include which of the following?

- A. A list of all healthcare providers**
- B. The purpose of the disclosure**
- C. The patient's full social history**
- D. A vague description of the records**

The correct answer emphasizes the necessity for the authorization for release of medical records to state the purpose of the disclosure. This requirement is fundamental for ensuring that patients understand why their information is being shared and with whom. By including the purpose, the authorization not only promotes transparency and informed consent but also supports compliance with legal regulations regarding patient privacy, such as those stated in the Health Insurance Portability and Accountability Act (HIPAA). Moreover, specifying the purpose helps to limit the use of medical records to the stated intent and protects against unnecessary or inappropriate disclosures, thus safeguarding the patient's privacy and maintaining trust in healthcare practices. In contrast, including a list of all healthcare providers may be overly broad and unnecessary, as the focus should be on the specific entities that will use the information for the stated purpose. The requirement for a patient's full social history is generally irrelevant to the authorization process and not typically necessary for the disclosure of medical records. Lastly, providing a vague description of the records does not meet the legal standards for informed consent, as it would not furnish the necessary clarity for patients about what specific information is being released.

8. A valid authorization must include which of the following elements?

- A. A patient's right to revoke statement**
- B. A re-disclosure statement**
- C. Signature and date by the patient**
- D. All of the above**

A valid authorization for the release of health information must indeed encompass several critical elements to ensure compliance with regulations such as HIPAA. Among these, the inclusion of a patient's right to revoke the authorization is essential. This right allows the patient to withdraw their consent at any time, contributing to the patient's control over their personal health information. Additionally, a re-disclosure statement is necessary. This statement informs the patient that the information disclosed could potentially be shared again, which provides transparency about the handling of their data and any associated risks. Furthermore, the signature and date by the patient serve as a verification of consent. This element confirms that the patient has willingly authorized the release of their information and that the authorization is current. Collectively, these components not only help protect the patient's privacy rights but also ensure that the release of information adheres to legal and ethical standards. Therefore, an authorization that includes all of these elements is considered valid and effective for processing requests for health information release.

9. What is the primary purpose of documentation within a patient's medical record?

- A. To create a legal liability for the healthcare facility**
- B. To ensure that communication between providers is effective**
- C. To serve as a basis for advertising the facility**
- D. To provide patients with unlimited access to records**

The primary purpose of documentation within a patient's medical record is to ensure that communication between providers is effective. Accurate and thorough documentation plays a crucial role in facilitating coordinated care among healthcare professionals. It allows providers to understand the patient's history, treatment plans, and any ongoing issues, which is essential for making informed decisions regarding the patient's care. Effective communication through documentation helps prevent errors, improves patient safety, and enhances the overall quality of care. It enables healthcare teams to collaborate effectively, ensuring that everyone involved in the patient's care is on the same page regarding treatment goals and actions taken. The other options do not align with the primary purpose of documentation. For instance, while documentation can indeed have legal implications, creating legal liability is not its main aim. Similarly, using patient records as a basis for advertising or providing unlimited access to records does not support the fundamental goal of improving caregiver communication and collaboration.

10. What is the difference between PHI and EPHI?

- A. PHI refers to medical records only, while EPHI refers to transcribed notes**
- B. PHI is any form of Protected Health Information, while EPHI refers specifically to Electronic Protected Health Information**
- C. PHI is information shared with family, while EPHI is for healthcare professionals only**
- D. There is no difference; both terms are interchangeable**

The correct answer illustrates a fundamental distinction in the realm of health information privacy and security. Protected Health Information (PHI) encompasses any individually identifiable health information that is collected, maintained, or transmitted by a healthcare provider, health plan, or healthcare clearinghouse, regardless of the format. This can include paper records, oral communications, and electronic formats. Electronic Protected Health Information (EPHI), on the other hand, is a subset of PHI that specifically pertains to health information that is created, received, maintained, or transmitted in electronic form. This distinction is crucial because it highlights the need for additional safeguards under the Health Insurance Portability and Accountability Act (HIPAA) for managing EPHI due to the unique risks associated with electronic data, such as cybersecurity threats. Understanding this difference is essential for professionals involved in the release of information, as it informs the measures they must take to protect health information in its various forms. Ensuring compliance with regulations surrounding both PHI and EPHI is critical for safeguarding patient privacy and maintaining trust in healthcare systems.

Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

<https://certreleaseofinfospecialist.examzify.com>

We wish you the very best on your exam journey. You've got this!